REFERRAL FOR SCHOOL-BASED MENTAL HEALTH (SBMH) SERVICES (04/02/2014)

School:_____ School Unique ID #:_____

School System:_____ System Unique ID #:_____

MH Provider:_____ MH Provider 3-Digit ID #:_____

MH Therapist:_____ MH Therapist 4-Digit Worker ID #:_____

Student Being Referred:_____ SSID #:_____

DOB:_____ Age:____ Race:___ Sex:___ MH Record # (If Accepted into Services):_____

Teacher:_____ Grade:____ Regular Ed:_____ Special Ed:_____

Exceptionality (or N/A):_____

Date of Referral:_____ School Counselor Making Referral:_____

Insurance Info: Medicaid:_____ AllKids:_____ Other:_____ None:_____

Parent or Legal Guardian (circle which) Name:_____

Student's Home Address:_____

_____

Student lives with Parent/Guardian? (Circle): YES NO If not, explain:_____

Home Phone #:_____ Cell Phone #:_____ Work/Other Phone#:_____

Parent/Guardian notified of referral by School Counselor and agrees to screening for MH services? (Circle): YES NO

CONCERNING BEHAVIORS (CHECK ALL THAT APPLY)

____ Reports Abuse	____ Victim of Crime/Violence	____ Suicidal Behaviors/Threats
____ Recent Traumatic Event	____ Peer/Social Problems	____ Parent/Child Conflict
____ Unusual Changes in Mood	____ Eating Problems	____ Substance Use Problems
____ Withdrawn/Depression	____ Recent Loss or Separation	____ Excessive Crying/Sadness
____ Angry/Agitated	____ Violent Outbursts	____ Fighting/Destroying Property
____ Resistant to Authority	____ Legal/Court Problems	____ High Risk Behaviors
____ Sexual Misconduct	____ Bullying (Perp./Victim)	____ Reports Sleep Problems
____ Inattentive/Hyperactive	____ Changes in Grades	____ Reports Fears/Phobias
____ Anxiety/Excessive Worry	____ Strange/Bizarre Behaviors	____ Reports Hallucinations

Notes:_____

_____

_____

Referral Accepted:____ Referral Denied:____ Reason for Denial:_____

Date Accepted/Denied:_____ Date Services Started:_____ Date Services Ended:_____